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LACERATION OF THE FEMALE PERINÆUM.

BEING A CLINICAL LECTURE.

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GENTLEMEN, — I intend to operate before you to-day for laceration of the female perinæum. This accident generally occurs among the poor who are attended by midwives or medical students. Rents of the perinæum are called complete or incomplete, according as the sphincter ani is or is not involved. Most commonly the rent is incomplete. The causes of a laceration may in general be divided into two. One cause is the common, faulty mode of supporting the perinæum. The diversity of opinion in this matter of support is very great. My advice to you is to make your support or retarding pressure (to imitate as nearly as possible the course of nature) directly to the head itself and not to the perinæum. When the perinæum is very rigid I relax it by hooking up and pulling forward the sphincter ani with two fingers passed into the rectum, while with the thumb of the same hand I make the needful restraining pressure upon the head. Lacerations from this cause generally stop short of the sphincter ani. Another cause of this injury is a forceps delivery. Why is a forceps delivery so often the cause of injury to the perinæum? In the first place, through a false delicacy, many physicians deliver the child under the sheet. They work in the dark, and of course cannot see what they are about. Under these circumstances, in difficult cases, the physician, worn out by direct traction, is very likely to brace one or both of his feet on the edge of the bed. The traction thus exerted is uncontrollable, and when the head passes the brim, which it usually does with a jerk, its momentum cannot be checked before it has torn its way through the perinæum. Again, in cases apparently requiring but little traction, the use of the forceps will often occasion a slight tear in the vagina, which the passage of the shoulders prolongs through the perinæum. Delivery by the forceps, even in skillful hands, will often produce a very bad rent involving the sphincter ani. My advice therefore to you is that *in general, and always with primiparæ, you take off your forceps as soon as the perinæum be-*

gins to bulge, and that you leave the final delivery of the head to the expulsive efforts of the patient.

But supposing that, in spite of the greatest care, a rent has been made. What is then to be done? First, discover the rent. You may smile, but you should know that from over-delicacy or carelessness on the part of the physician lacerations are continually escaping notice until it is too late to perform the primary operation; the torn flesh has healed, preserving the rent. You should make it an inflexible rule after every delivery either to look at the perinæum or to gauge its thickness between the thumb in the vagina and the index finger in the rectum. If you discover a rent your method should be, immediately after the delivery of the placenta, to pass deeply two, three, or even more wire sutures, securing each one by merely twisting its ends together. Each suture is entered about an inch from the cutaneous margin of the wound, and is made to emerge on the mucous membrane of the vagina very near the edge of the raw surface. The first stitch must always be put in a little *below* the lower angle of the wound. Should the lochia obscure the parts, dam them back by a sponge pushed well up into the vagina, and don't forget to remove the sponge before you twist the ends of the wires together. Then draw your patient's water, put a pad between her knees, and bind them together. If the rent is incomplete no other treatment is necessary except that of keeping the bowels bound for a week. But when the rent extends to or through the sphincter ani, or when several deep sutures have been introduced, then the same precautions must be gone through with, namely, those of drawing off the urine, of binding the knees together, and of keeping the bowels costive, etc., as I shall enjoin upon you when describing the after-treatment of the secondary operation. While warmly advocating the primary operation, I have not found it on the whole so successful as the secondary. Thus by the former I have had two failures so far, by the latter none. Failure in the primary operation is usually owing to the irregular surface of the rent, which prevents exact coaptation, and to the lochial discharges which insinuate themselves between the surfaces of the wound and hinder union.

Let us suppose, however, that, as in the case before us to-day, the laceration was not discovered until entirely too late for immediate treatment, and that the woman has gone about until this day with vulva and anus torn into one great opening. A woman under these distressing conditions suffers untold miseries. The sustaining power of the vaginal column is impaired by such an injury to its perineal abutment, and the bladder and womb tend to sag down. The vulva gapes, it acts no longer as an elastic, air-tight valve, and the womb and vagina become irritated and congested by the air which gains access to them. The air thus sucked up into the vagina is liable to escape audibly, con-

stituting that disorder which the Germans call "garrulity of the vagina." Again, rents of this kind are attended with more or less impairment of the sexual function. The sexual act is blunted on the part of the male, and imperfectly responded to by the female. The shortness of the vagina causes the semen to be rejected, and the woman becomes barren. Last and most grievous result of all, there will be a constant involuntary escape of flatus, and an incontinence of the fæces when at all liquid. The woman's clothing is soiled without warning; her person becomes repulsive to her husband, and her company undesired by her friends. Seclusion and mental anguish undermine her constitution. To keep her bowels costive the woman is obliged to rely upon daily doses of opium.

Having traversed all this extremely valuable ground as a preliminary, I am now ready to speak to you about the secondary operation, and then to perform it in your presence. This woman, five years ago, in her first labor, met with the mishap of having her perinaum very badly torn. Her physician, a man of large experience, put on the forceps, and in delivering the head this accident happened and was allowed to go by unnoticed until too late for the primary operation. I have had the patient thoroughly etherized while I have been talking to you, and put in the lithotomy position. Early yesterday morning she took a full dose of oil, and this morning one grain of opium in order to restrain the bowels from further action. To avoid ether-vomiting she has eaten a very light breakfast.

While the assistants keep the vulva on the stretch I begin by shaving off the hair around the rent, and then pass two fingers into the bowel in order to smooth out the overlying rugous vagina. Next, with a curved pair of scissors, I trim the rectal edges of the rent, and snip off from its vaginal surface a thin paring of mucous membrane. This trimming is continued for an inch and a half up the posterior wall of the vagina, and then the sides of the perineal rent are denuded for a space a little broader and longer than the cicatrix of the original perinaum. On account of the vascularity of these parts and the valveless veins I prefer the half-crushing action of the scissors to the clean cut of the knife. Close to the lower edge of the raw surface two small arteries are spurting little streams of blood, but I shall not tie them lest the ligatures should act as foreign bodies and prevent union. By nipping each with a *serre-fine* I stay the bleeding. These little clip-springs will be found to be of great service in this operation. I have nipped the skin off both of the sides, and the wound is now ready to be closed, but before doing so let me carefully sponge every part of the bleeding surface to see whether any portion of mucous membrane or of skin has escaped the scissors. I see that all the little ridges of mucous membrane have been snipped off, and now I am ready to pass in the tures.

A sharply-curved needle held in the jaws of a needle-holder, and armed with silver wire (to avoid the constant threading of the needle with the wire I have passed a fine silk thread through the eye of the needle, and tied a half knot in it. In making my stitches I pass the end of the wire through the loop of the thread, and simply bend it over), is entered nearly half an inch below the lower angle of the wound in the left buttock on a level with the *lower* margin of the anus. By my finger in the rectum I pilot this needle through the recto-vaginal septum, so that by one sweep it completely girds the rectal rent and emerges at a corresponding point of the skin on the right buttock. This suture was first devised by Dr. Emmet, and a very important one it is whenever the sphincter ani is torn through or a limited portion of the recto-vaginal septum is involved. In passing let me enjoin upon you this advice: Whatever the degree of laceration, and whatever the nature of the operation, namely, whether primary or secondary, *the point of entrance and of exit of the first suture should always be fully half an inch below the lowest angle of the wound.* The perinæum proper I shall now close by five other metallic sutures. The cutaneous points of these sutures should be an inch from the margin of the rent, and each suture should pass through the vaginal mucous membrane very close to the edge of the raw surface. After carefully sponging away the blood I pass the ends of the lowest suture through the hole in the handle of the forceps, and while drawing upon them firmly push the latter down upon the skin. The adjuster being removed a perforated shot is slipped over the ends of the wire. This is next seized in the jaws of the compressor, and after being firmly pushed home is clamped. Each suture is in like manner secured by a single shot, and the free ends of the wire clipped off. Some operators only twist the ends of wire, but I always clamp with shot.

The operation is now ended, but before removing our patient to her bed let me empty her bladder. While withdrawing the catheter I keep my finger closely applied to its mouth so that the few drops of urine retained within it shall not escape and trickle over the wound. I also fold up a soft napkin, put it between her knees, and bind them together. I used to advise the employment of a self-retaining catheter in these cases, but it produced in one instance such a severe attack of cystitis by being allowed to remain in longer than proper that I have never recommended its use since. *So I tell you, in view of this possible accident, never to employ the self-retaining catheter, but to have the water carefully drawn twice or thrice daily. This can be done without unbinding the knees, namely, by flexing the knees and thighs upon the abdomen, the woman being upon her back, and so introducing the catheter.* Our patient's bowels must be kept locked up. Enough opium to ease the uncomfortable tension of the sutures, say one grain every four to six hours,

will be enough. If she is annoyed by painful flatus which does not yield to teaspoonful doses of the fluid extract of valerian, a flexible catheter should be carefully introduced into the rectum. On the seventh or eighth day I shall cut and remove every suture except the rectal one. On the morning of the ninth day four ounces of warm olive-oil will be slowly injected into the rectum, followed two hours later by a soap-water enema. Should hardened fæces over-distend the rectum the nurse must break them up either by her finger, a hair-pin, or the handle of a spoon. When the medicine has operated I will remove the last suture.

After the bowels have been thoroughly opened they should be again locked up for four or five days more, and then be daily kept open by a mild aperient. The patient should have her knees bound together, and stay in bed for at least two weeks, and for a week longer should not go out of her room. During this latter time she should walk about but little, and keep her knees close together. Should a fistulous opening remain, fuming nitric acid should be applied, and the sides should be coaptated with sutures.

DIVISION OF THE TENDO ACHILLIS IN FRACTURE OF THE LOWER THIRD OF THE FEMUR; A CASE OF T FRACTURE.

BY M. A. MORRIS, M. D. HARY., CHARLESTOWN.

In fractures of the leg where there is a tendency of the superior end of the lower fragment to override the upper one, and in fractures and dislocations about the ankle-joint when it becomes difficult or impossible to place and retain the fractured parts in position, owing to contraction and rigidity of the muscles of the calf, division of the tendo Achillis has been recommended, and excellent results from that procedure have been reported. In fractures of the lower third of the femur, various methods have been adopted for correcting the tendency of the upper end of the lower fragment to tilt out of position and backwards into the popliteal space, such as flexing the limb and placing it on a double inclined plane, etc. It seems to be pretty generally conceded that treatment in the straight position gives the best results in fractures of the thigh, for if the limb be placed in the flexed position there is a greater liability to trouble from ankylosis, which results in so many cases of fracture, particularly when situated near the knee-joint; and, again, it is impossible to keep up a proper amount of extension in the flexed position. When the fracture is in the lower third of the bone and near the condyles, the upper end of the lower fragment is apt to be drawn backward, making it difficult and sometimes impossible to keep the ends of the bones in apposition, as the writer has found from expe-

rience. In one case, which was treated in the straight position by competent surgeons, tilting backward of the lower fragment took place, and the result was delayed union, with protracted confinement to bed, and a firm ankylosis which it required a long time to recover from.

Another case was also slow to recover, and when the splints were finally removed a large, irregular callus could be felt just above the popliteal space.

None of the authors, so far as we have been able to learn, recommend tenotomy of the tendo Achillis in such cases except Bryant, who says:¹ "I have taught this method for the last two years, but have had only one opportunity of testing its value." The case here reported seems to have been a proper one for the trial of this method.

The subject was a man aged forty, of delicate constitution, who had suffered in early life from a disease of the left knee-joint, which left the head of the tibia dislocated somewhat outwards and backwards on the condyles of the femur, but good use of the joint was regained. About four years ago he sustained a fracture of both bones of the same leg, which made it shorter than its fellow. Two years ago, while returning from his place of business, he fell on the icy sidewalk and fractured the femur of the same side. The bone was broken obliquely, the line of fracture extending upwards and backwards two and a half or three inches from its articular end. There was also a longitudinal fracture separating the condyles, which could be freely moved and felt to grate against each other; there was considerable shortening, but little swelling about the joint. The muscles of the thigh were soft and flabby, but notwithstanding this, when extension was made and the limb put in position, the upper ends of the lower fragments projected backwards, and could not be kept in position, on account of the traction of the gastrocnemius muscle.

Owing to the facts that this limb was already shorter than the other and that the patient would be very liable to have an ankylosed knee-joint, with considerable additional shortening, it was deemed best to place the limb in the straight position, and to divide the tendo Achillis, in order to paralyze the gastrocnemius. Under ether, the tendon was divided and the tendency to displacement overcome. The limb was placed on a Macintyre's splint, and extension applied in the usual way by sticking-plaster straps bandaged to the leg and attached to a transverse foot-piece, from which swung a weight over a pulley at the foot of the bed. Counter-extension was made by elevating the foot of the bed; a cold-water dressing was applied over the joint, which began to swell a little, when an ice-bag was applied and the swelling subsided. At the end of eight weeks the patient was up, and a month later was able to move round, and soon could flex the knee almost to a right angle. The amount of shortening was about half an inch.

¹ Pract. of Surgery, page 867.

A fracture of the femur is a comparatively rare accident, and when it does occur is liable to lead to grave joint trouble and ankylosis. Hamilton says (page 431): "More fortunate results than these may, indeed, be hoped for, inasmuch as they have occasionally been noticed, but they cannot fairly be expected. In a majority of cases such accidents have demanded, either immediately or at a later period, amputation."

Bryant says (page 866): "These cases are serious on account of the joint complication, for some stiffness of the joint generally follows, but not always."

That we did not have more swelling of the joint in this case appears rather singular. The only reasons we should suggest for its absence are the following: the synovial membrane and parts about the joint may have been so lacerated as to allow the escape of the fluids secreted into the cellular tissue outside, which absorbed them as fast as formed; or the ice-bag may have prevented it.

It would appear to us there can be no objection to division of the tendo Achillis in such cases as those mentioned above. Its advantages are quite evident. The limb can be treated in the most favorable and comfortable position, and the bones placed in the best position for union, thereby accelerating it and lessening the liability to shortening, protracted confinement to bed, and ankylosis.

FRACTURE OF THE PATELLA.

BY WILBUR F. MORGAN, M. D., BALTIMORE, MARYLAND.

MARCH 30, 1876, I was called to see Mrs. McG. for the first time. She was a small, delicate woman, weighing about one hundred pounds, twenty-seven years old, married, and the mother of two children. She lived in a small street in a healthy location in this city. I found her sitting on a lounge, nervous and anxious, suffering from the effects of a fall. Loss of power of motion being complained of, I examined and found complete horizontal fracture of the right patella, the bone being neatly divided into two equal fragments. The fracture was caused by the knee striking the rim of a basket which stood in the way when she fell. I temporarily dressed the fracture by the application of laths, laterally and posteriorly, until the primary irritation and swelling subsided.

April 2d. Mrs. McG. remained upon the lounge until to-day, when I removed the primary bandage and applied the starched apparatus. I cut the binder's boards to fit perfectly the shape of the leg, and sufficiently long to extend from the instep to the upper third of the femur upon the inside and the trochanter upon the outside of the leg. The boards, thoroughly softened, were then adapted closely to the leg, care

being taken to prevent anything like constriction of the parts in the application of the bandages.

April 3d. The bandage has hardened, and fits the limb like an elastic stocking. The patient has been sitting up on the lounge all day. Eats her full allowance of her every-day food, and complains only of the irksomeness of her position. Her secretions and excretions are natural.

April 13th. I have seen the patient every other day since the last record, the case giving me some anxiety because the patient began to *walk* about the lower floor of the house the day after I applied the starched bandage, namely, the fifth day after the accident, and she has been going through the same anti-traditional *régime* every day since. There has been no unpleasant symptom arising therefrom, and upon close observation I discovered that nature knew better what was good for the patient than the surgeon. The close adjustment of the apparatus kept the limb immovably extended; there was no muscular action, and could be none. The quadriceps, instead of contracting, lay quietly in its case of bandage, and gravitation, acting more perfectly than a Malgaigne hook, allowed the upper fragment of the patella to fall into contact with the lower fragment, which was carefully supported by an extra turn of bandage. From time to time I opened the bandage at the knee, and was more than pleased to see the perfect apposition in which the fragments lay. As the bandage had become loosened from atrophy of the muscles and soft parts I reapplied it, and she immediately walked across the floor. Except for the halt in the gait, no one would suppose that she had so lately received so severe an injury.

April 20th. I found Mrs. McG. at the wash-tub, where she had been all the morning. As there was no unfavorable symptom present I allowed her to pursue her own line of action, although I was certain it was the first time on record that a patient with a fractured patella had ever washed and wrung out clothes on the twenty-second day after such an accident.

Of course the question arises, What was the result of such treatment? May 10th, 15th, 19th, and 24th I removed the bandage for ten minutes and made flexion; there was a little stiffness for the first day or two. After that I could flex the knee as far as I thought advisable.

May 31st, I removed the outside board and cut down the other to a slight support, allowing a little motion. She is to take off the splint, and exercise the knee every day for a time without any support. Her health is perfect. The patient being naturally thin the shape of the bones is easily seen beneath the skin. The general form of the fractured patella is the same as its uninjured fellow, its circumference being slightly greater. Its horizontal diameter is one sixteenth of an inch greater, and the perpendicular diameter is a scant quarter of an inch longer. The action of the joint is perfect, the patient suffering no in

convenience of any kind, except that at times in descending a step she is apt to relapse into the habit, contracted when the leg was in splints, of stopping and putting that foot first, an action now unnecessary.

July 12, 1877. I to-day examined the patella and found it of the same dimensions as reported last year, and the action of the joint perfect. I think there is cartilaginous union.

RECENT PROGRESS IN GENITO-URINARY SURGERY.

BY THOMAS B. CURTIS, M. D.

Urinary Mucus. — Méhu¹ shows that urine contains no mucin, and that the name mucus, as generally applied, is a misnomer. What is usually called mucus is a visible deposit, occurring either in the form of a suspended cloud or in that of a more or less thick stratum, and consisting, in health, of vesical and other epithelium (urethral, vaginal, etc.), with occasional crystals (uric acid, urates, oxalate of lime); in disease, white corpuscles, blood-disks, spermatozoa, fungi (vibriones), renal epithelium, casts, phosphates, etc., may be found. The chief ingredient of the so-called mucus, however, is pus, accompanied by *serin* and *pyin*. The latter substance, like mucin, is precipitated by acetic acid, but the precipitate is not redissolved by an excess of mineral acid, as is the case with the precipitate of mucin. The urine contains under no circumstances any substance presenting the characteristics of mucin as described by Scherer.

Decomposition of Urine. — Important experimental investigations have been made of late upon this subject. Dr. Bastian had for some time maintained the assertion that the decomposition of urine with formation of organisms could be made to occur under circumstances which precluded both the survival of preëxisting organisms or germs, and the penetration of organisms from without. In other words, he maintained that spontaneous generation took place. M. Pasteur² showed that in a correctly performed experiment three conditions must be fulfilled: first, the urine to be experimented upon must be purified by adequate boiling; secondly, the liquor potassæ added must be similarly purified; thirdly, the flasks used must be purified by heat (*flambés*) and guarded from contamination. When these conditions are fulfilled the urine *never* becomes decomposed, and organisms *never* appear in it. Dr. Bastian having neglected to purify his flasks, a fallacy was shown to exist which utterly invalidated all his experiments as regards the attempted demonstration of the putrescibility of uncontaminated urine.

Experiments of a novel character were made recently by P. Caze-

¹ Journal de Pharmacie et de Chimie, February, 1877, page 106.

² Comptes rendus de l'Académie des Sciences, July 23, 1877.

neuve and Ch. Livon,¹ with a view to elucidating the conditions under which urine is liable to undergo decomposition. A ligature was thrown around the prepuce of a dog, and urine was allowed to accumulate in the bladder during five hours, after which the dog was sacrificed and opened, and the ureters and urethra were tied. The bladder was then removed and kept exposed to the air during many days at various temperatures ranging from 80° to 122° F. The experiment was repeated several times. In no case did organisms make their appearance in the contained urine, whatever its original reaction, unless the bladder had been perforated.

M. Musculus² showed that the so-called mucus contained in the ammoniacal, ropy urine derived from cases of chronic cystitis yields, by precipitation with alcohol and desiccation, a soluble ferment, which has the property of bringing about the chemical change whereby urea and water combine to form carbonate of ammonia. This dried ferment, dissolved in urine, rapidly sets up the ammoniacal decomposition of the latter. We must therefore admit, said Musculus, the correctness of the idea formerly entertained that the vesical mucus acts as a ferment. The ferment of urea, he added, has none of the characteristics of organized or formed ferments. It, on the contrary, resembles closely the soluble ferments, or diastases.

Pasteur and Joubert,³ having repeated the experiments of Musculus, admit the existence of a soluble ferment capable of changing urea into carbonate of ammonia. They assert, however, that the ammoniacal change of urine or of solutions containing urea is invariably accompanied by the presence of organisms, and that normal urine remains acid and free from decomposition so long as it does not contain bacteria. They are therefore of opinion that the soluble ferment of Musculus is a product of the organisms, these being indispensable for its formation.

M. Berthelot⁴ takes a similar view of the urea ferment, and shows the analogy existing between this soluble ferment secreted by urinary organisms and the soluble ferment which is produced by the yeast-plant, and which has the property of causing the inversion of cane-sugar.

From the foregoing experimental evidence the conclusion may be drawn that the ammoniacal decomposition of urine cannot take place without either the bacterial contamination of the urine or the admixture of the soluble ferment artificially prepared from previously contaminated and decomposed urine. In either case, actual or preëxisting bacterial contamination is an indispensable condition of the ammoniacal change. Therefore the decomposition of urine within the bladder must always be due to the introduction of bacteria or germs from without.

¹ *Comptes rendus de l'Académie des Sciences*, September, 1877. *Gazette hebdomadaire*, September 27, 1877, page 625.

² *JOURNAL*, January 14, 1877, page 11. *Archiv der Physiologie*, xii. 214.

³ *Journal de Pharmacie et de Chimie*, September, 1876, page 206.

⁴ *Ibid*, page 208.

The ammoniacal decomposition of urine occurring within the body is held to be an important factor in certain diseased states of the urinary organs. With regard, however, to the proper management of cases in which the ammoniacal change is liable to take place, opinions and practice vary considerably.

Thus, in paralytic retention of the urine, Mr. Jonathan Hutchinson¹ thinks that there is much doubt as to whether the usual practice of relieving the bladder by the catheter is judicious, so constantly does inflammation of the bladder supervene after the use of instruments has been instituted. He inclines to adopt the plan of allowing the bladder to fill and overflow of itself.

It has, however, been suggested² by Traube, Niemeyer, and many others that in cases where the catheter is frequently used the decomposition of previously healthy urine is actually caused by the mechanical introduction on the catheter itself of germs of bacteria, and can with almost absolute certainty be prevented by proper antiseptic precautions.

The subject of ammoniacal decomposition and its relations to cystitis came up before the Pathological Society of New York.³ Dr. Janeway expressed the opinion that hospital patients were more liable to cystitis than others for the reason that the urinals were not apt to be thoroughly cleansed, and consequently that there was more danger of bacteria finding their way up the urinary tract. Especially was this the case when the penis was allowed to soak for any length of time in a urinal. Dr. Seguin concurred in this opinion, and was convinced that with care in keeping catheters and urinary utensils clean, even in cases of paraplegia, cystitis could be prevented for an almost indefinite period.

The damage liable to result under certain circumstances from bacterial contamination of urine within the bladder does not seem to be limited to the production or exasperation of cystitis. The view has been maintained⁴ that the bacterial decomposition could extend upwards through the ureters into the pelves, and even into the tubuli of the kidneys, thereby setting up a severe form of disease called *pyelo-nephritis parasitica* (Klebs). Similar views have been expressed by Dickinson⁵ in relation to the so-called "surgical kidney" and the resulting febrile disturbance, which he proposes to call *uriseptic fever*.

For the prevention of all these evils (cystitis, pyelo-nephritis, uriseptic fever, etc.) various measures, both preventive and curative, have been suggested. Measures of prophylaxis, already alluded to, consist

¹ D. Campbell Black. *Functional Diseases of the Urinary Organs*. London. 1875. Page 36.

² *British and Foreign Medico-Chirurgical Review*, July, 1877, page 97. Ebstein, in Ziemssen's *Cyclopædia* (American translation), vol. xv., pages 569 and 576.

³ *New York Medical Record*, October 6, 1877, page 636.

⁴ Ziemssen's *Cyclopædia* (American translation), vol. xv., page 569.

⁵ *The Lancet*, 1875, vol. i., page 342.

in avoiding the introduction of bacteria in or upon catheters or other instruments. This end is said to be attainable by scrupulous cleanliness, and through the purification of instruments by means of the efficient use of antiseptic agencies; in other words, by applying, in the management of the distended bladder, precautions similar to those considered necessary in cases of spinal abscess.

The restoration of the normal acidity of the urine, together with freedom from organisms, has been sought in a variety of ways, but often with doubtful results. A certain measure of success has been claimed for various internal remedies. Benzoic acid, administered in daily doses of about thirty grains, during one or two weeks, seems to have produced the desired results in the hands of Professor Gosselin and A. Robin.¹

Salicylic acid, when internally administered, is eliminated by the kidneys, partly unchanged and partly transformed into salicin and salicyluric acid.² This drug has been tried in cases of vesical catarrh by Fürbringer,³ who states that under its influence when given internally in comparatively small doses (fifteen to thirty grains) the causes and results of the ammoniacal fermentation of the urine disappear. The production of pus from the urinary mucous membrane is, however, not prevented. Dr. Celli⁴ bears similar testimony to the utility of salicylic acid in cases of vesical catarrh.

Senator,⁵ on the other hand, having tested the antiseptic action of salicin internally administered in one recent and two chronic cases of cystitis, found that the ammoniacal condition of the urine was unaffected by its use. Senator's own experience is in favor of the treatment of vesical catarrh by the balsams, especially by balsam of Peru.

Those who may feel tempted to try salicylic acid in diseases of the urinary organs may be glad to know beforehand that, according to Professor Gubler,⁶ this drug exerts a decided action upon the kidneys, which in cases of renal disease may go so far as to occasion diminution of urine and marked albuminuria. Dr. Buequoy agrees with Professor Gubler upon this point, and queries whether certain sudden deaths of patients who had been taking salicylic acid might not be due to uræmia. The drug is therefore probably not so harmless as had been supposed.

Besides internal remedies, various antiseptic agents, injected in solution into the bladder, have been advocated and largely tried, with a

¹ *Comptes rendus de l'Académie des Sciences*, January, 1874.

² Byasson. *Société de Thérapeutique*, October 10, 1877. *Gazette hebdomadaire*, October 19, 1877, page 672.

³ *Berliner klinische Wochenschrift*, No. 19, 1875. *Archives générales de Médecine*, August, 1875.

⁴ Il Morgagni. 1876. *Revue des Sciences médicales*. Paris. January 15, 1877.

⁵ *Berliner klinische Wochenschrift*, No. 14, 1877. *Medical Times and Gazette*, August 4, 1877.

⁶ *Société de Thérapeutique*, October 10, 1877. *Gazette hebdomadaire*, October 19, 1877.

view to bringing the action of germicides to bear upon the organisms contaminating the contents of the inflamed bladder.

Carbolic acid so used does not yield good results, says Dr. Van Buren.¹ It cannot be used in sufficient strength in the bladder, says Dr. R. F. Weir,² to test its power as a germicide, since a two per cent. solution is necessary to kill bacteria. Moreover, the researches of Musculus, alluded to above, have shown that the properties of the soluble urea ferment are not impaired by the admixture of carbolic acid in any strength.

Borax dissolved in warm water (fifteen to twenty grains to the ounce) is a favorite vesical injection for cases of chronic catarrh. Sir H. Thompson, Van Buren and Keyes, and R. F. Weir all recommend it for this purpose. M. Dumas³ having shown that borax has in a marked degree the peculiar property of checking the action of all the soluble ferments, we should expect it to exert a favorable influence in diminishing or arresting the ammoniacal fermentation of urine, the latter being occasioned, as was stated above, by a soluble ferment.

Constant irrigation of the bladder with warm water has also been used with benefit in chronic cystitis, with the result of restoring the acidity of the urine and allaying the inflammation and irritability of the bladder. "It is well known," says Dr. Ellis,⁴ "that in cystitis, sooner or later, the products of inflammation are liable to decompose in the bladder, and that, as a consequence, the urine becomes ammoniacal, and, in turn, by its irritating properties, increases the inflammation." With a view to breaking this vicious circle, Dr. Ellis advises the complete removal of the products of inflammation, as well as of the urine itself, before either have had time to undergo decomposition. Intermittent irrigation often proving ineffectual, it seemed desirable to try the effect of a constant current of warm water through the bladder. This was done with success by means of apparatus consisting of a double-current catheter, rubber tubing, and a vessel.

It has been shown, as already said, that the penetration of organisms into the bladder is an indispensable condition, without which the ammoniacal decomposition of urine within the body cannot take place. Considerable stress has, moreover, been laid upon the evil consequences which are liable to result from the bacterial contamination of urine within the bladder. Evidence is, however, not wanting to show that organisms can occasionally obtain access to the interior of the bladder, and even establish themselves there for long periods of time without the production of serious consequences to the patient. M. du Cazal⁵ pub-

¹ Van Buren and Keyes. *Diseases of the Genito-Urinary Organs*, 1874, page 198.

² The Hypertrophied Prostate. *American Clinical Lectures*. New York. 1876. Page 243.

³ Schützenberger. *Les Fermentations*. Paris. 1873. Page 236.

⁴ *JOURNAL*, April 5, 1877, page 393.

⁵ *Gazette hebdomadaire*, November 21, 1876, page 740.

lishes a paper, with several cases, the object of which is to show that organisms can exist in a bladder containing habitually acid urine without the urine becoming alkaline, and without the production of any noteworthy disturbance of the urinary organs. He says that bacteria, when introduced into a healthy bladder, are soon evacuated without producing any alteration of the urine; but that when chronic cystitis exists they then establish a permanent foothold within the bladder, being continuously reproduced. The author of this report can confirm some of the statements of Du Cazal, having now under observation a patient whose freshly passed urine is always slightly turbid, owing to the presence of organisms. These comprise filamentous bacteria, in the form of threads and snarls and more or less active rods. The urine is generally neutral or alkaline, occasionally feebly acid, but never ammoniacal. At intervals of several days or a week a thick, white discharge, composed of agglomerated crystals of triple phosphate, is passed at the close of micturition. This was the only symptom complained of by the patient, who was able to retain his urine *ad libitum*.

It seems, therefore, as if certain favoring conditions were necessary to enable bacteria to become domiciled within the urinary organs and to exert their full powers for evil. These conditions, without which the bacterial contamination of the urine seems comparatively harmless, appear to consist in stagnation of the urine within the bladder, together with certain alterations of the urine itself, namely, alkalinity or diminished acidity, high specific gravity due to concentration, and the admixture of pus, blood, or albumen. When all these conditions coexist, as is not unfrequently the case, then the penetration or introduction of organisms into the bladder not unfrequently constitutes a serious complication of the original disease.

The Treatment of Cystitis by Milk Diet. — Dr. George Johnson¹ calls attention to the beneficial influence of an exclusive milk diet in the treatment of some forms of cystitis. In one of the cases reported by him, a severe cystitis of two years' duration was rapidly and completely cured without any other treatment being employed. The milk may be taken cold or tepid, not more than a pint at a time, lest indigestion be caused. Some adults will take as much as a gallon daily. With some the milk agrees better if boiled, and then taken cold or tepid. If so rich in cream as to disagree, it may be partially skimmed. Dr. Johnson prefers unskimmed milk as having less tendency than skimmed milk to cause constipation. When the vesical irritation and catarrh have passed away, and the urine has regained its natural character, a gradual and cautious return may be made to the ordinary diet.

"If," says Dr. Johnson, "I might venture to give a hint to my surgical colleagues and friends, I should say that an exclusively milk diet would probably be found very suitable for most patients during the first

¹ The Lancet, December 16, 1878, page 847.

few days after the operation of lithotrity, the object being, of course, to lessen as much as possible the inflammation and catarrh resulting from the mechanical irritation of the mucous membrane of the bladder. I have recently seen two cases in which the vesical irritation and catarrh resulting from a stone in the bladder were much mitigated by the milk diet, the patients being thereby brought into a more favorable condition to undergo successfully, the one the operation of lithotomy, the other that of lithotrity."

Dr. Donkin¹ also advocates the use of a milk diet in certain inflammatory affections of the urinary organs. He, however, has a decided preference for skimmed milk, which has a higher specific gravity than unskimmed milk, is proportionately richer in casein and salts, and is more powerfully diuretic. Constipation resulting from its use is a sign that the treatment agrees, and can be obviated by judicious management. Skimmed milk, on account of its diuretic property, is very useful in the treatment of Bright's disease, especially when complicated by dropsy. Many cases occur, says Dr. Donkin, in which it is necessary to begin with doses of a wineglassful, or even less, and gradually to increase the quantity.

PROCEEDINGS OF THE SUFFOLK DISTRICT MEDICAL SOCIETY.

A. L. MASON, M. D., SECRETARY.

OCTOBER 27, 1877. Eighty-one members were present, the president, Dr C. D. HOMANS, in the chair.

Pneumono-Dynamics. — DR. G. M. GARLAND delivered an address² to the society on this subject, which he summarized as follows: —

I have shown clinically and experimentally, —

(1.) That the letter S curve of flatness (in pleuritic effusion) was first accurately described and traced through its various modifications by Prof. Calvin Ellis, of Boston.

(2.) That the letter S curve of flatness corresponds in shape to the lower border of the lung, and in position to the line of apposition between the lower border of the lung and the upper border of effusion.

(3.) That the letter S curve can be traced only in the erect position, and when the play of the lung is not hampered by adhesions, and that its persistence throughout the various stages of an effusion indicates the absence of adhesions in the lower part of the lung at least.

(4.) That the letter S curve is pathognomonic of a fluid effusion in the pleural cavity, but that it is impossible to judge from any variations in the curve as to the nature of the fluid present.

(5.) That the dull triangle, which I have described, corresponds to the pos-

¹ The Lancet, December 30, 1876, page 921.

² Soon to be published by the author in the form of a monograph.

terior inferior part of the lung, and that this portion of the lung is not, in the erect position, separated from the chest wall by effusion until the amount of fluid has become relatively very large.

(6.) That a recognition of the dull triangle is very important for the detection of the curve of flatness, especially in cases of hydro-thorax, when the neglect of this region has led to the general but erroneous idea that the surface of the transudation is horizontal in that class of cases.

(7.) That an effusion does not immediately intrude between the lung and the lateral chest wall, but that such intrusion occurs last of all, whatever be the position of the patient.

(8.) That a pleuritic exudation does not compress the lung in the manner universally taught, but that, on the contrary, the effusion exerts a negative pressure by virtue of its weight.

(9.) That the lower part of the lung does not become first compressed and then plunged into the fluid beneath, but that the entire lung contracts symmetrically throughout.

(10.) That the lung does not, properly speaking, swim upon an effusion, but that, by virtue of its retractility, it supports the entire body of the effusion, together with the diaphragm, until the weight of the fluid exceeds the lifting force of the lung.

(11.) That the position and shape which the lung assumes when associated with an effusion are determined by the balance between the weight of the fluid and the elasticity of the lung.

(12.) That the position and shape which the effusion assumes are determined by the varying degrees of retractility in different parts of the lung, and by the position of the patient, complications of course being left out of consideration.

(13.) That the excess of weight of an effusion is free to act according to its specific gravity.

(14.) That the diaphragm does not bag down until the weight of the effusion exceeds the lifting force of the lung, and the same holds good for obliteration of the intercostal spaces.

(15.) That the heart, mediastinum, etc., are not pushed out of place by an effusion, whether of air or fluid, but that those parts are drawn over by the opposing lung. Enormous effusions may, of course, increase the displacement.

(16.) That friction sounds in the early stage of pleurisy are not interrupted by the effusion separating the lateral pleural surfaces, but that they cease because the respiratory muscles of the affected side are weakened and unable to cause sufficient motion for the production of those sounds.

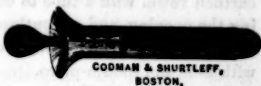
(17.) That the negative pressure of the lung favors absorption *into* the pleural cavity at the end of expiration.

(18.) That the action of the intercostal muscles favors absorption *out* of the pleural cavity at the inception of inspiration.

(19.) That the negative pressure of the lung favors the diastolic repletion of the heart, as shown by Marey and others, and that impairment of the retractility of the lung must therefore be accompanied by symptoms of imperfect heart supply, such as cardiac irregularity of action, diminished tension in arteries, and venous stagnation, as suggested by Dr. T. B. Curtis.

Dr. Garland regarded some of the points in this summary as original with himself, while others were merely demonstrated, as he thought, in an original and conclusive manner.

Anal Speculum. — DR. JOHN P. ORDWAY showed a new anal speculum, of which the accompanying cut is a representation, which he considered, with a few improvements, would commend itself to the profession as superior to all others now in use. The tube is three inches long, three quarters of an inch in diameter, perfectly straight, with a flange or bell-mouth. A longitudinal section of the tube, beginning at the distal end and extending to within an inch of the flange, is cut away, leaving a fenestra two inches long and about half an inch wide. The wooden obturator is so well fitted that with care in the withdrawal very little if any of the mucous membrane or abnormal growths is caught in the fenestra. The instrument being of the same diameter throughout does not dilate the sphincter unduly.



Most anal specula enlarge towards their proximal ends, thus preventing a proper view of the rectum. The unbroken circumference of the tube for about an inch also commends this instrument. Dr. Ordway stated that the instrument was the invention of Dr. Squier, who had been guided somewhat by his personal experience as a sufferer and by suggestions from Dr. Ordway.

Internal Strangulation. — DR. BARNES presented the specimen with the following history: —

W. B., twenty-eight years old, with a good family history, was attacked with severe pain in the abdomen on the morning of October 14th, without previous symptoms or cause, so far as could be learned. The bowels had moved freely the day before. When seen, soon after the beginning of his illness, the entire abdomen was painful and tender. Morphine was administered subcutaneously, and gave relief until evening, when he took an opium pill, which was soon followed by vomiting. He passed a restless night.

October 15th. The pulse was accelerated and the temperature raised half a degree. There was some tympanites, with increased pain and tenderness.

October 16th. The severity of the symptoms was augmented, but there was no vomiting. Dr. Clark, in consultation, advised local depletion in addition to the opium and stimulants he was then taking, but he sank until death ensued, about nine o'clock in the evening, fifty-six hours from the time he was first taken sick.

The patient presented the usual symptoms of peritonitis with obstruction of the bowels, except vomiting, which occurred once only, at the time mentioned after taking the opium pill. The bowels did not move, and no effort was made with that object, although a simple enema was ordered on the first day.

Autopsy twenty hours after death. There was about one pint of bloody serum in the peritoneal cavity. Three feet from the junction of the ileum with the cæcum were a number of convolutions of the small intestine, of a deep claret color and slightly adherent to the omentum and abdominal walls. At this point a diverticulum, four inches long, communicating with the intestine and united to the mesentery at the other extremity, formed with the intestine

a ring through which this portion of the ileum had protruded and become strangulated. The appendix vermiformis was normal in size and position. No further examination was made.

Hospital Inhaler. — DR. H. W. WILLIAMS showed an inhaler which was used for hospital purposes by Dr. Mackenzie, of London. It consisted of an earthen vessel with a tube to conduct air to the bottom, an elastic cap covering the opening, and a mouth-piece.

DR. LYMAN asked how it differed from an ordinary wide-mouthed flask with tube and mouth-piece.

DR. WILLIAMS said only, perhaps, in respect to its durability and cheapness.

DR. E. L. PARKS exhibited an instrument for deep injections into the urethra. It was made of a piece of elastic catheter, four inches long, surmounted by a flange to which a soft India-rubber tube was fastened, enabling the patient to make a more efficient use of astringent solutions.

DR. WEEKS reported the three following cases:—

Carcinoma Uteri unattended by Uterine Symptoms. — Mrs. S., aged forty-six, twice married without issue, was first seen by me in August, 1877. She had been failing about four months. From her previous history I learned that she had never suffered from uterine derangements, nor felt any of the pains that usually attend disease of that organ.

There was a large accumulation of ascitic fluid. The uterus was depressed, enlarged, and immovable. Paracentesis abdominis was performed and nine pounds of fluid were withdrawn, after which an induration was observed in the right inguinal region, also another in the epigastric region. The diagnosis was cancer of uterus and peritonæum.

The patient failed gradually until September 20th, when she died. In the mean time the fluid was withdrawn three times, and each time about the same quantity as at first.

At the autopsy cancerous disease of the uterus, left ovary, and peritonæum was found, yet during my attendance I had at no time observed any stomach derangement, nor was pain a prominent symptom. The bladder and bowels acted freely until the last.

Fibroid Tumor of the Uterus complicating Pregnancy. — October 24, 1877, I was called to attend Mrs. G., aged thirty-nine, first pregnancy, then in labor. I found that although the os uteri was well dilated and yielding, and the pains were strong, the head was not descending satisfactorily. I allowed the labor to progress naturally for eight or ten hours, when I became convinced that the delivery could not be accomplished unaided. I administered ether and proceeded to deliver with forceps. The head lay in the L. O. A. position. The forceps were easily applied, but the head could not be made to engage at the superior strait. After several ineffectual efforts I withdrew the forceps and introduced the hand to turn, when I found an interstitial fibroid tumor as large as the child's head, which lay wedged between the head and shoulders, thus preventing descent.

The child was delivered by podalic version. The tumor arrested the delivery of the head, which was accomplished only after much effort. The mother lived about thirty-six hours.

The autopsy revealed a tumor as above stated; also a rupture of the bladder, which, without doubt, was the cause of death.

Cirrhosis of the Liver.—The specimen presented was taken from the body of a man, aged forty years, who had for many years used stimulants of different kinds freely. He has, for four years or more, had diarrhoea, usually most troublesome at night.

One year ago I withdrew from the abdomen about ten quarts of fluid. At that time the edge of the liver descended about two inches below the border of the ribs, was very hard, and appeared enlarged. By the free use of scoparius the fluid was prevented from accumulating; still the patient did not regain much strength. After a few weeks' attendance he was, at his own request, permitted to care for himself, until, one year from the first tapping, I was called to withdraw the fluid a second time, and then again in a month. The patient survived the last operation only three days, dying from accumulation of fluid in pleural and pericardial sacs.

Notwithstanding that the liver was so completely disorganized, yet there was an absence of pain and distress in the stomach, also of hiccough and vomiting, symptoms which we are taught to look for in connection with disease of the liver. Jaundice appeared during the last few months.

Invalid's Bedstead.—An invalid's bedstead was exhibited by Mr. James Goodwin, the inventor, at the request of members who had found it serviceable. By means of a crank, which can be easily worked by an attendant, the patient can be placed in various positions without manual assistance. The sheets can be changed, the mattress turned, etc., without discomfort.

HOSPITAL HYGIENE.¹

THE writer of the Boylston Prize Essay of Harvard University, for 1876, has had abundant opportunity for the study of his subject in having had much practical experience as house surgeon at Bellevue Hospital, in being a member of the standing committee on hospitals of that admirable organization, the New York State Charities Aid Association, and in having spent a summer abroad for the purpose of investigating the subjects of training nurses and hospital construction.

The first chapter of the book before us is devoted to a very interesting history of hospitals. It appears that the Buddhists and the fire-worshippers, to whom all forms of life are sacred, were probably the first to establish infirmaries for the ill and injured of the poorer classes. The writer differs with other students of history in thinking that "hospitals for the sick poor did not exist to any extent, if at all," among the ancient Greeks and Romans; he holds that the *valetudinaria*, the sick rooms adjoining the temples, indeed the temples themselves converted into hospitals, were chiefly for the wealthy classes. Of course, this is a matter in which the silence of history forbids our forming an exact opinion; but if the statement is true that much of the knowledge of

¹ *Hospitals: Their History, Organization, and Construction.* By W. GILL WYLLIE, M. D. New York: D. Appleton & Co. Pp. 340.

medicine possessed by the Buddhists was acquired through the advantages for study afforded by their hospitals (page 55), it is difficult to see where the great physicians of Greece and Rome got their knowledge, unless from similar sources. During the first sixteen centuries of the Christian era the development of the hospital idea is attributed chiefly to the feeling of brotherly love so fostered by the Church of Rome. The invasion of Europe by the Moors is not even mentioned, and the same educational importance, therefore, is not attached to that great event as is insisted upon by Lecky, Desmaisons, and others. The early hospitals were entirely in the hands of the ecclesiastics, and were constructed chiefly on the ground of convenience of administration. Still, the leading men knew that something better was desirable and practicable, even in the middle of the sixteenth century; and this is clearly shown in Sir Thomas More's description of the hospital in Utopia, which was to be so well arranged, with trained nurses and expert physicians, in the suburbs of the city, and with ample provision for the classification of diseases, that people when ill would be only too glad to go there. In the Thirty Years' War some attempts were made at a sanitary service; but almost nothing of importance was really done until the eighteenth century, which is especially marked by Captain Cook's discovery that seamen can keep their health in long voyages, by John Howard's inquiries into the lazarettos and prisons of Europe, with the consequent reforms, and by the practical application of Boerhaave's teachings to the uses of daily life by his pupils, Sir John Pringle and Dr. Brocklesby. The work of Sir John Pringle marks the advance of the eighteenth century, as that of Florence Nightingale marks the present century; and Dr. John Jones, one of the founders of the New York Hospital, who visited Europe in 1772, published an intelligent account of hospital requirements, thereby introducing Pringle's views in this country. The committee composed of Laplace, Lavoisier, and others in 1786 reproduced the same ideas in France also. But Brocklesby deserves the credit of putting into practice the best theory of the day, and his work is so striking and important that we give a short sketch of it here, especially as it is barely mentioned in the essay.

In 1758, when the wounded were sent from France to the Isle of Wight, he built an open, one-story shed for a hospital, large enough for one hundred and twenty patients. He found that "remarkably fewer died, though treated with the same medicine and the same general regimen, than died anywhere else." In 1760, he constructed another shed hospital in the same place for forty patients, during a fever epidemic. The mortality was very slight, and he says of it: "I candidly ascribe their fortunate escape more to the benefit of a pure, keen air they breathed therein every moment than to all the medicines they took every six hours or oftener." In 1761 and 1762 he got excellent results from similar "mansions for the sick," built of thatch and board, — at these times having several separate buildings. In 1762 he did not lose a single man by death during the encampment.

In the early part of the present century Rush and Bell in our country, and other equally eminent men in Europe, have done excellent work. Any one familiar with Bell's address on Hospital Hygiene in 1848, and the Massachusetts General Hospital, would hardly agree to the statement on page 43, that

previous to 1859 neither England nor the United States had a civil hospital that would compare favorably with the plan proposed by Dr. John Jones in 1773. In the latter half of this century, thus far, the essential advances in construction of hospitals have been, in the words of our author:—

(1.) That the hospital should be placed on a large area of ground, so that the pavilions can be widely separated from the administrative buildings and from one another.

(2.) That the wards should be *only one story* in height, and be ventilated by openings along the ridge of the roof.

(3.) That the ward-pavilions should be put up, not to remain for generations to come, but only so long as they are free from infection; and that, when once they are infected, they should be destroyed and replaced with entirely new structures.

The accomplishment of this desirable change in the construction of hospitals has been due to the lessons of the Crimean war, followed by the pavilion plan of Herbert, St. Thomas, and the Boston City Hospitals; and to the American civil war with its sanitary commission, and the Franco-Prussian war, of which the direct result was the barrack or one-story hospital. But these good results could not have been obtained without the years of patient labor by the sanitarians of the preceding years, nor until the masses had gained sufficient knowledge of this matter to coöperate to a certain extent.

Thus far, however, only a few of the one-story hospitals have been built. "The Roosevelt Hospital, opened in 1871, has one one-story pavilion to show as the influence of the experiences of the war; but New York city has had six other large new hospitals, all of which are massive, many-storied buildings, costing immense sums of money; and one of these, the last, is seven stories, and on a space of ground seventy by one hundred and seventy-five feet." The new wards of the two hospitals in Boston, those in Leipsic and Dresden, and the Rotherham, Berlin, and Philadelphia hospitals are commended as regards these points, and as being the only cited examples of the barrack system.

The remaining ten chapters—about one hundred and eighty pages—were written "hurriedly, during March;" they embrace a variety of subjects. The author has evidently availed himself of the modern literature of his subject, and gives a statement of the present position of our knowledge on all the important questions, from the relations between pauperism and hospitals and the value of appointments in them, over the whole ground of ventilating, draining, etc., to their use as educators of students. Although there is nothing which is not already familiar to us in this part of the essay, and although it calls to mind Lamartine's famous apology for a long letter that he had not time to write a short one, it will be of use to those who wish for the sort of facts which it contains; but what is most easily written is not always the most easily read.

The consideration of insane asylums was, by the terms of the prize, not to be included, but the author devotes a couple of pages to that subject. He says (page 179): "In this country most of our institutions are constructed on the massive, monumental style and managed on the economical, prison system, and there is still too much of the iron bars, dark cells, and strait-jackets of the old Bedlam. Besides, the medical attendance is scant and necessarily more or

less inefficient, and the nursing is wretched; in fact, the nurses do not pretend to be anything more than keepers, and the class from which they are selected is the same as that from which keepers for criminals are derived. Uncommon brute force seems to be considered the most desirable quality to make a good nurse for an insane asylum." This accusation is so unfair and untrue that we feel it a duty to protest in the strongest terms against it. When the author adds (page 180), "Even in our best institutions for the insane it will be found that there are several hundred patients to each physician, and the nurses too few in number and not above the grade of household servants," it is evident that his sources of information were entirely misleading.

THE BOSTON DISPENSARY AND VENEREAL DISEASES.

WE have learned with regret that the authorities of the Boston Dispensary are much inclined to abolish the department of venereal diseases. The expenses of the institution have been so great that it is thought necessary to reduce them, and it is proposed to do so by suppressing this branch. We are sure that the profession will agree with us that such a course would be a serious misfortune to the community in many ways. Let us be understood as discussing this question quite independently of that of the abuse of medical charities. The trustees have no idea of closing the whole institution; we therefore have to consider only whether they are wise in economizing at the expense of this department, and we can say confidently that they are not. There is an old-fashioned feeling in Boston that venereal disease is not a respectable thing to have to do with under any circumstances; that the victims are suffering for their sins or those of their fathers, and that it is almost flying in the face of Providence to assist them. Barbarous and absurd as this view is, thus plainly stated, there is no doubt that it prevails extensively in minds of a certain order. Like other cruel superstitions it springs from ignorance. The well-meaning gentlemen who hold it forget that a large number of those afflicted with syphilis have contracted it blamelessly. Virtuous wives almost without number are suffering for the sins of their dissolute husbands, and bringing children into the world doomed to lives of suffering and disease. One of the chief purposes of the department is to treat these unfortunate ones, many of whom can be very materially benefited, for, in spite of the persistent nature of the disease, it is well known that in certain forms, at least, it is very amenable to treatment. We imagine that this movement may have been suggested by the number of cases of gonorrhoea, which of late appears to have been unusually prevalent among the rough element. We own we do not see why one of these scamps should not be treated as readily as his brother who has had his nose bitten off in a drunken brawl; but be that as it may, we protest against sacrificing the innocent sufferers by excluding them with these worthless offenders.

Another great objection to the proposed step is that, to our shame be it spoken, this is the only clinic for venereal diseases in the city of Boston. The disease itself is prevalent enough, but the Dispensary is the only institution that has utilized it for purposes of instruction. The loss of this clinic would be a most serious injury to medical education.

MEDICAL NOTES.

— The *Medical Examiner* states that Dr. Küstner (*Virchow's Archiv*, vi. 77) is of opinion that the streaks on the skin of the abdomen of pregnant women are not seated in the rete Malpighii, as most authors have assumed, but are due to a separation of the deeper layers of the cutis and of the subcutaneous cellular tissue. The epidermis is not torn through, but tightly stretched and rendered transparent, so that the more deeply seated colored tissues gleam through it. The distention ceases suddenly when delivery takes place, the separated layers come together again, and the epidermis is thrown into folds which often project considerably for some days after birth. These folds are the commencement of the transverse markings by which old streaks may be distinguished from new ones. When the folds appear the epidermis loses its transparency, — indeed, it becomes more opaque than the surrounding unaltered portions; it also loses moisture and looks glossy, especially when light falls upon it obliquely; the difference in appearance between these marks and the surrounding skin may be compared with that between the finger and the adjacent epidermis. This glossiness of the streaks, however, is sometimes absent, especially in young women pregnant for the second or third time, in whom the interval between each pregnancy has been short. The breadth of the streaks does not depend upon the thickness of the abdominal integuments; in some cases pigment becomes deposited in the streaks soon after delivery, and as a general rule the chloasma uterinum is more marked after delivery than during pregnancy.

— Of Churchill's tincture of iodine, of which the formula is:—

R ^y Iodinii puri	3 lii.
Potassii Iodidi	3 ss.
Spiritus rectificati	f 3 xij.
Alcohol	f 3 iv.
Solve.	

Dr. Parvin, in *The American Practitioner* for November, 1877, says: After employing this tincture for thirteen years, I know no single agent used in the local treatment of uterine disorders at all equal to it. It may be used as a stimulant, alterative, counter-irritant, caustic, and as a hæmostatic, and for the purpose of exciting absorption of hypertrophied tissue. Its hæmostatic properties are of especial utility in the treatment of hæmorrhagic endometritis, and after the use of the curette or forceps in the removal of the smaller intra-uterine growths, hypertrophies of the glandular and vascular elements of the lining membrane.

— In consequence of the departure of members of the medical profession for the seat of war there is a great scarcity of doctors in Russia, and epidemics which are raging are accompanied with a high mortality. At St. Petersburg the death-rate during the last quarter is reported as high as thirty-five per one thousand, at Moscow thirty-eight, and in the southern towns from forty to forty-five.

— Professor Hebra has been elevated to the *Ritterstand* of the Austrian empire as *Ritter des ordens der eisernen Krone, Classe III.*

— The value of respectable professional standing is enforced in an editorial in *The Medical Record*, which gives an instance of its importance in a case where a physician appeared as a witness in court. In a recent case of this sort in New York city a medical gentleman, "who openly boasted that he did not care to become a member of any medical society, was severely handled by the attorney of the opposite side, who made it appear to the jury that the gentleman in question was not regular, and that his testimony should be taken with the allowance given to all suspicious witnesses. The result was what might have been anticipated. There is no argument, even in a court of law, against respectable connection and high standing in the profession, while a suspicion of the contrary is always a handle for an adversary; the moral of all of which is that it is safer to be respectable, even if it does incur the necessity of belonging to some recognized medical organization." We would remind our contemporary that more than membership is necessary for respectability.

— We take the following *verbatim* from *The Canada Lancet*. Comment would be superfluous.

"NOVEL EXPERIMENT.— Dr. Fuller, of Montreal, has conceived the novel idea of trephining out portions of the skull of an idiotic child of two years old, to allow the expansion of the brain, and thereby afford the faculties an opportunity of developing, which had not been previously the case. Since the operation there has been a marked improvement in the mental condition, and a paralysis of the arm, with general coldness of extremities, has been quite remedied. The faculties of intelligence have brightened up considerably, and, encouraged thereby, it is Dr. Fuller's intention to take out another piece of skull and note the result."

OBITUARY.

DR. BENONI CARPENTER, of Pawtucket, Rhode Island, was stricken down in the midst of apparent health by apoplexy, November 20th, and died without intervening consciousness November 22, 1877. Dr. Carpenter was born in Rehoboth, Massachusetts, March 12, 1805; he graduated at Brown University in 1829, a member of the first class graduated under the presidency of the late Dr. Francis Wayland. In 1832 he graduated at the Jefferson Medical College, Philadelphia, and in 1833 commenced the practice of his profession in Seekonk, Massachusetts. In 1837 he removed to Pawtucket and at once entered upon a full practice.

In the year 1862 he was commissioned surgeon of the twelfth Rhode Island infantry, a nine months regiment. At the expiration of its term of service, he was transferred to the fourteenth regiment of heavy artillery, serving in that capacity till the close of the war.

In 1865 he was appointed medical director of the department of Carrollton, Louisiana, and served in that position till 1867, at which time President Johnson disbanded the colored regiments constituting that department. He then returned to his home in Pawtucket, but never resumed active practice.

He was elected member of the Rhode Island house of representatives in 1867, and of the Rhode Island senate in 1868. He was appointed prison in-

spector of Rhode Island in 1869, and continued in office till the present year. He was for many years an active and efficient member of the school committee of Pawtucket, evincing great interest in the proper culture of the young. He was intensely loyal to his profession, jealous of her rights, ever seeking the promotion of her interests in her multiform relations. A despiser of shams and their exponents, he was one of the pioneers who moved to eliminate the latter from the corporate ranks of the Massachusetts Medical Society, of which he was an efficient member, and for many years a councilor. In this effort he suffered the obloquy of personal friends, the effect of which seemed to inspire him with still greater enthusiasm to accomplish the removal of that which he believed was compromising science and the honor and reputation of his profession. Courage, therefore, to do right as he saw the right, regardless of the effect upon himself, constituted a distinguishing feature of his life.

Nor was this feature of character limited to professional application; it was prominent in every sphere of life. For more than forty years he proclaimed his hostility to the use of alcohol as a beverage or for "side-board" purposes in unmeasured terms, both from the platform and in private councils; and though this course aroused personal antagonisms, and curtailed his professional business, yet he continued to proclaim his convictions with a degree of self-abnegation rarely witnessed, but truly refreshing in these days when *policy* is so prone to rule the hour.

His funeral obsequies, with those of his wife, whose decease antedated his own but a few days, were solemnized in the Congregational church, where hundreds assembled to pay the last tribute of love and respect to one who in life had sought to make the world better for his having lived in it, and who had succeeded in his varied relations in establishing confidence in his purity of purpose.

J. R. BRONSON.

ATTLEBORO, MASS., November 24, 1877.

ABUSE OF MEDICAL CHARITIES: A REMEDY.

MESSRS. EDITORS, — In this, as in all civilized communities, every man, woman, and child has, or may have for the asking, a regular medical attendant.

Let any one, therefore, who wishes the advantages of a hospital, dispensary, or other medical charity, present a card from his or her regular medical attendant stating that, in his opinion, the bearer is worthy and makes the application with his approval. This requirement will inflict no hardship on the applicant; besides, a little effort will make him value his privilege the more highly.

On presentation of such a card, let the official in charge stamp it with the seal of his institution, and the number of weeks or months it will hold good for the applicant. Let the official also clip off one of the corners of the card.

The applicant may thus get the attendance desired, — with the supervision of the regular attendant, if necessary.

Let all other applications for in or out patients not accompanied by such a card be refused by all the institutions, excepting, of course, urgent cases.

If, after having been received at any hospital or charity, the applicant for any reason goes to another institution, his stamped and clipped card will at once expose him; and after having his name recorded at the new place as one of the irregulars, and having another corner of his card clipped off, he may be properly cautioned, referred back to the first institution, and dismissed.

The second clipping of the card will expose to the first institution such and similar unfaithfulness, as the card should be presented at every visit.

When the card-time is out (or before, for sufficient cause) the recipient, with the assent of his regular physician and on giving up his card, may receive a new card and go to any other institution if either party wishes a change.

A quarterly interchange among the several charities of printed alphabetical lists of the names of all new applicants and the physicians recommending them would soon reveal impositions if any were attempted.

Blank cards of proper size and style might be kept at all the charities, and furnished to physicians and applicants as convenience required.

The above plan seems perfectly feasible and just to all parties. If the managers of the several medical charities earnestly desire to assist the worthy poor and to prevent imposition, let them try it. The superintendents of the several institutions could easily arrange the details, which may be exceedingly simple, and put the plan into operation without delay. Try it!

MEDICUS.

THE ABUSE OF MEDICAL CHARITIES.

MESSRS. EDITORS, — I have read with much interest the controversy between your JOURNAL and Dr. Rogers. I am very loth to enter any argument which will cause too much publicity, but as I have had nearly eight years' experience in practicing our profession in a town of about twelve thousand (12,000) inhabitants, where no public charity is given to the sick, I feel a right to express my opinion, which coincides with every one of my brethren here, so far as I can learn. I think that a public charitable medical institution, even in as small a town as ours, to say nothing about the larger cities, would be a blessing, not only to those who are deserving of charity, but to the physicians in practice. Any one who is small-minded enough to cheat the physician by going to a place where advice and medicine can be obtained gratis, when he or she is well able to pay a fee, is just the one never to pay when he or she happens to ask a private consultation. My experience has been one of hard labor in obtaining my fees from just such persons, and after the small percentage was obtained by close following and oftentimes by the aid of legal force, it was hardly enough to pay for the trouble. Any physician who enters the practice without some little property to aid him is worthy of pity if he is to depend upon this class of practice for his support. There are rare instances where a young practitioner has stepped into a good field without the help of money, but I have seen so many cases of ill success, and continue to see them, that I think it is safe to conclude that the views of the JOURNAL are the nearest correct.

I am yours, with respect,

H. F. BORDEN, M. D.

BROCKTON, November 24, 1877.

LETTER FROM NEW YORK.

MESSEURS. EDITORS, — It has been announced that the connection existing between the College of Physicians and Surgeons and Columbia College will soon be severed by the board of trustees of the latter institution. The College of Physicians and Surgeons was chartered in March, 1807, by the regents of the University of the State of New York, pursuant to an act of the legislature passed March, 1791. The first course of lectures began in November, 1807, and the first class, consisting of eight, was graduated in 1811. Before the Revolution, namely, in 1768, the Medical School of New York was organized in connection with King's, now Columbia, College through the exertions of Drs. Peter Middleton and Samuel Bard, but the war coming on soon after, many of the professors were called away to more urgent duty, and the school was broken up. After the return of peace the college was reorganized. The present school grew out of this, and was a department of Columbia College until 1813. In 1860 it again became a department of Columbia, although it had its own board of trustees, who managed the school entirely independent of the college, made appointments to the staff of instructors, or rather confirmed those the faculty chose, Columbia having not the slightest voice in the matter of instruction or graduation; in fact it was a department of the college only in name. Columbia is now a wealthy corporation, and pecuniary aid has been sought for on the part of the Medical School. The desire of more control in the management of the school has often been expressed by the trustees of the college, and as the latter were unwilling to give aid unless they had some control over the course of study and requirements for graduation, the connection has proved unsatisfactory to both parties. So after seventeen years the college has determined to sever its nominal connection with the school. It is unfortunate that the two could not have been united under one head. The fact is becoming more apparent every day that the friends of a more thorough course of medical study for those preparing themselves for a professional life have nothing to hope from the present medical schools; there is still to be the same wrangling over hospital appointments, and the same bidding for students. It is rumored that the trustees of Columbia College propose to organize a medical department of their own. If this is done, it will be placed upon a proper basis, and will rank among the best schools in the country. Columbia is abundantly able to do this. It has an income from ground-rents of two hundred and sixty thousand dollars a year, and this income is increasing. New York has better facilities for clinical instruction than any other American city, and it should possess one of the best schools. It is a remarkable fact that not a school in the city has an endowment fund worth speaking of, notwithstanding that one college has been for a number of years making strenuous efforts to accumulate such a fund. Can the cause of their want of success be that the general profession and the public are unwilling to give their money to aid a private enterprise?

Shortly after the opening of the present session the faculty of the College of Physicians and Surgeons voted to deny admission to a colored student, on the ground that his presence in the lecture-room might be objectionable to the

other students; at least, this is the ground that the friends of the college allege as the reason for the action taken. As far as I have heard any expression of opinion in regard to this action of the faculty, it is one of disapprobation. It is certainly reviving issues that were supposed to have been settled, and cannot fail to bring the college into unpleasant notoriety. I am informed that it has pleased the Southern students, but it will injure the college in many sections of the country. Upon the fact becoming known, quite a number of letters were received by the rejected student from prominent medical schools, offering to receive him as a student, among them one of the Philadelphia schools. He has entered the medical department of the University of Michigan.

The county medical society has just appointed a new committee, namely, one on ethics. What it will amount to remains to be seen. There has always been a class of men whose whole time seems to be devoted to finding out what is wrong in the deportment of their brother practitioners, — whether they live up to the code of ethics, — whose highest ambition appears to be to “run” societies and pick motes out of their brothers’ eyes. If the control of the committee is given to men of this class, not much good will be accomplished. The code of ethics is more strictly construed here than in other sections of the country, in some points. Physicians are not allowed to put their cards in the medical journals, as seems to be the custom in Boston, while in other points they are more lax. I do not believe that the spirit of the code is often broken, and the offense would have to be very great to obtain even a vote of censure from the society.

New York city does not suffer for the want of physicians. According to the Medical Register there are one thousand one hundred and ninety-eight regular practitioners, one hundred and fifty-six homœopathic, eight hundred and ninety-six who are embraced under the title of “miscellaneous,” whatever that means. More than one half of the regular practitioners in the State are located in New York city. Seventy-nine physicians have left the city during the past year, and thirty-two have died. One hundred and seven new names have been added to the directory, so we manage to keep up our number.

The report of the Commissioners of Charities and Correction for the year ending December 31, 1876, has been issued. There are three general hospitals under the charge of the commissioners, namely, Bellevue, Charity, and the Homœopathic. Patients are sent to the different hospitals as follows: all acute medical and surgical cases go to Bellevue; subacute and chronic medical and surgical cases are equally divided, as far as possible, between Charity and the Homœopathic, unless a patient manifests a preference. According to the above plan there were treated 5116 patients at Bellevue, 1570 of which were either ambulance or police cases; 8621 at Charity, and 3077 at the Homœopathic. The death-rate at Bellevue was 12.37 per cent., at Charity 8.48, and at the Homœopathic 6.07. The high death-rate at Bellevue is due to the kind of cases admitted. The difference between Charity and the Homœopathic is apparently greatly in favor of the latter institution, but a careful analysis of the two tables indicates but little difference. It is to be regretted that a table of all diseases treated, with the result, is not given, for without statistics of this kind the statements are valueless. I find that among the deaths are

fifty-five still-born children and twelve premature births. Now these should not have been included in the mortality table of Charity; deducting these reduces the number of deaths to 622 and the rate to 7.10 per cent. Charity is the maternity hospital of the department, and lying-in cases are not admitted elsewhere; deaths connected with this division should be excluded in the comparison. According to rule, the Homœopathic Hospital should have received about as many cases as Charity did, but we find it treated only a little over one third as many. A large percentage of deaths at Charity is due to diseases necessarily fatal, and in which treatment is useless. An approximation to the death-rate in diseases curable, in the two hospitals, in the absence of any other data, may be obtained by deducting the number of deaths from incurable diseases occurring in the two institutions, and then getting the percentage. Adopting this plan, we find that there were five deaths from aneurism, twenty-six from cancer, eighteen from marasmus, seventy-three from chronic Bright's disease, twenty-nine from old age, fourteen incident to confinement, and twelve to atelectasis, making one hundred and seventy-seven to be subtracted from the list of deaths at Charity, and reducing the percentage of deaths to 5.25. From the Homœopathic table of deaths deduct sixteen from Bright's disease, five from cancer, one from old age, and five from general paresis, making twenty-seven, and then getting the percentage we find that it amounts to 5.21. It should have been stated that the number of deaths was taken also from the number of admissions in both cases. I understand that the homœopathic medical journals have been referring to this apparent low death-rate at the Homœopathic Hospital in comparison with that at Charity as a proof of better results obtained by the plan pursued at the former institution. The tables given by both hospitals do not prove anything. We hope in the next report that a table of diseases will be given, and the results, whether the patients were discharged cured or relieved, or whether they died. It has been the custom in the report of Charity Hospital to record a few post-mortem examinations. The Homœopathic staff have incorporated in their report this year four cases with the post-mortem examinations.

CASE No. I. "Chronic pleurisy and hepatic abscess. . . . Physical examination. Dullness over the entire right side from clavicle to Poupart's ligament. Heart displaced; apex tilted upwards, striking the thoracic walls at fifth intercostal space and to the *right* of the sternum. . . . The right pleural cavity was found full of pus."

CASE No. IV. "Addison's disease. . . . His skin had a deep, almost olive-green, bronzed appearance. . . . There was severe hacking cough, with bloated limbs and other symptoms of general phthisis. On examination after death the kidneys and supra-renal capsules were found to be in a normal condition."

COMPARATIVE MORTALITY-RATES FOR THE WEEK ENDING NOVEMBER 17, 1877.

	Estimated Population, July 1, 1877.	Total Mortality for the Week.	Annual Death-Rate per 1000 for the Week.	Death-Rate for the Year 1876.
New York	1,077,228	466	22.49	27.46
Philadelphia	850,856	268	16.38	22.88
Brooklyn	527,830	186	18.32	24.31
Chicago	420,000	124	15.35	20.41
Boston	363,940	130	18.57	23.89
Providence	103,000	40	20.19	18.34
Worcester	52,977	23	22.58	22.00
Lowell	53,678	15	14.53	22.21
Cambridge	51,572	9	9.08	20.54
Fall River	50,372	10	10.32	22.04
Lawrence	37,626			23.32
Lynn	34,524	13	19.57	21.87
Springfield	32,976	7	11.04	19.69
Salem	26,739	7	13.61	23.57

BOOKS AND PAMPHLETS RECEIVED. — Illustrations of Clinical Surgery. By Jonathan Hutchinson, F. R. C. S. Fasciculus IX., Plates XXXII.-XXXV. Philadelphia: Lindsay and Blakiston. (For sale by A. Williams & Co.)

A Guide to Therapeutics and Materia Medica. By Robert Farquharson, M. D. Enlarged and adapted to the United States Pharmacopœia. By Frank Woodbrey, M. D. Philadelphia: Henry C. Lea. 1877. (From A. Williams & Co.)

Points in the Diagnosis of Hepatic Affections. By E. G. Janeway, M. D. American Clinical Lectures. New York: G. P. Putnam's Sons. 1877.

Pyæmia or Septicæmia. By B. A. Watson, M. D. (Reprinted from the New York Medical Journal.)

The Physician's Self-Copying Prescription Book. Wendell A. Anderson, M. D. Chicago: Hadley Brothers. 1877.

The Physician's Daily Pocket Record and Visiting List. Philadelphia: Office of Medical and Surgical Reporter.

Proteus or Unity in Nature. By Charles Bland Radcliffe, M. D. Second Edition. London: Macmillan & Co. 1877. (From the Publishers.)

The Transactions of the Indiana State Medical Society. Indianapolis. 1877.

Transactions of the International Medical Congress of Philadelphia. 1876. Edited by John Ashhurst, Jr., M. D. (For sale by A. Williams & Co.)

A Treatise on Gonorrhœa and Syphilis. By Silas Durkee, M. D. Sixth Edition. With eight colored Illustrations. Philadelphia: Lindsay and Blakiston. 1877. (For sale by A. Williams & Co.)